DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:		A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 04/25/2023			
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC			STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD WYNDMOOR, PA 19150						
STATE LICENS	SE NUMBER: 591902								
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0000 F 0690 SS=G	Based on an Abbreviated S complaint, completed on A that Ivy Hill Post Acute Nu not in compliance with the CFR Part 483, Subpart B, F Facilities and the 28 PA Co Pennsylvania Long Term C related to the health portion	pril 25, 2023, it was detursing and Rehablitation, following requirements Requirements for Long Tode, Commonwealth of Care Licensure Regulation of the survey process.	, was of 42 Ferm Care ons	F 0690	TITLE:	(X6) DATE:			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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-	TEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ N OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395525		A. BLDG:00_ B. WING:		04/25/2023	
IVY HILL REHABILI	VIDER OR SUPPLIER: POST ACUTE NURSING OF TATION LLC E NUMBER: 591902	&	STREET ADDRESS. 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 1			F 0690			
SS=G	483.25(e)(1)-(3) Bowel/Black \$483.25(e) Incontinence. \$483.25(e)(1) The facility in continent of bladder and borservices and assistance to more clinical condition is of is not possible to maintain. \$483.25(e)(2)For a resident based on the resident's complicative must ensure that (i) A resident who enters the catheter is not catheterized to condition demonstrates that (ii) A resident who enters the catheter or subsequently recommon appropriate treatment and see infections and to restore complete the condition of the catheter as serice in the catheter of the catheter as serice in the c	nust ensure that resident wel on admission receiver a such that consider the prehensive assessment, the facility without an indunless the resident's clinical catheterization was necessary to be a spossible unless the demonstrates that and an antinent of bladder receives to prevent urinary timence to the extent possive assessment, the fact who is incontinent of both the previous and the property of the property of the property of the prevent urinary timence to the extent possive assessment, the fact who is incontinent of both the property of the prevent urinary timence to the extent possive assessment, the fact who is incontinent of both that continent of both that continent is the prevent urinary timence to the extent possive assessment, the fact who is incontinent of both that continents are prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence to the extent possible unless that the prevent urinary timence that the prevent urinary timence to the extent possible unless that the prevent urinary timence that the prevent urinary timence the prevent urinary timence the prevent urinary timence that the prevent urinary timence the prevent urinary	who is es ss his attinence ce, the welling ical essary; lling r the es y tract ssible. e, based ility wel		Preparation & execution of the preparation of this plan of condoes not constitute admission agreement of the facts allege conclusion set forth in this statement of deficiencies. The of correction is prepared and executed solely because it is required by both federal and Element 1 -Corrective action Resident RI lab drawn during hospital stay. Element 2 Identification of a Residents All residents with indwelling catheters have the potential traffected. Element 3 Systemic Changes Unit Manager/Designee will resident charts with urinary	orrection or or od or o	Completion Date: 05/16/2023 Status: APPROVED Date: 05/12/2023
	receives appropriate treatme much normal bowel function		re as		catheters to ensure that labor testing was completed timely past 14 days and follow up w	y in the	

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTI	2) MULTIPLE CONSTRUCTION: (X3) DAT COMPLE		ΣY	
		395525			00	04/25/2023	
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902		&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
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F 0690	Continued from page 2			F 0690			
SS=G	This REQUIREMENT is not met as evidenced by:				physician as needed for any concerns identified.		
					A contracted state approved will initiate directed in service licensed nurses on the lab princluding the need to obtain a resident with an indwelling catheter in a timely manner. Newly hired licensed nurses receive education during orion annually and prn. Newly admitted residents wireviewed in the daily clinicate to ensure lab orders related to indwelling urinary catheters completed as ordered. Element 4 Quality Assurance. Unit Manager/Designee will the Order Listing Report in commetting and audit weekly a monthly x 2 to ensure laboratesting is completed timely it residents with indwelling urinary catheters.	cing to all occess labs for gurinary will entation, Il be I meeting o are e review clinical 4 then tory n all	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
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IVY HILL REHABILI	VIDER OR SUPPLIER: POST ACUTE NURSING (TATION LLC	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
STATE LICENS: (X4) ID	TE LICENSE NUMBER: 591902 B) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D		EICIENCV	ID	DROUMDEDIG DE ANTOE CODREG	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	OF BEFICE NOTES (EACH DES		PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0690	Continued from page 3			F 0690			
SS=G					catheters.		
					Needed corrections will be addressed as they are discovery		
					Findings to be reported mon QAPI team for review and a necessary.		
							l

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING: _		04/25/2023	
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F 0690	Continued from page 4			F 0690			
SS=G							
	Based on clinical recordinterviews, it was determined to the control of the contr	•					
	to obtain a urinary stud		-				
	resident with an indwe	,					
	experiencing bleeding	from the urinary catl	heter for				
	one of five residents re	`	· 1				
	failure resulted in actua						
	was transferred to the l						
	urinary track infection,	•	d two				
	units of PRBC (packed	i red blood cells).					
	Findings include:						
	Review of Resident R1 Data Set - a mandatory assessment tool), dated	periodic resident					
	that the resident was ac	dmitted to the facility	у,				
	November 12, 2022, w	•					
	cerebral artery stroke (
	language deficits, as w deficits and visual defe		-				
	body) and urinary tract	* *					
	ood, , and armary truck						

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395525		B. WING: _	00	04/25/2023	
IVY HILL REHABIL	VIDER OR SUPPLIER: POST ACUTE NURSING OF THE PROPERTY OF THE P	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 5			F 0690			
SS=G	in any part of the urina kidneys, ureters, bladder review of the MDS revishort and long term car required extensive assist transfer and had an individual Review of Resident R1 November 13, 2022, rethe potential for complifoley catheter with a sure of a foley catheter due Interventions included signs and symptoms of Review of Resident R1 8, 2023, at 7:29 p.m. by E11, "Nurse received reatheter draining bright (incontinent) care the rewith bright red blood a clots small to largest the appeared to be in no particular assistance."	er and urethra). Convealed that the resider memory impairment stance with bed mobilities welling urinary catholic care plan initiated evealed that the residuations related to the apporting diagnosis of the associal pressure to observe foley catholic autilities. It is nursing notes date y licensed nurse, Emesident in bed with the tred blood, and during esident's diaper was along with bright reduce size of a quarter. It	tinued nt had ent, polity and eter. lent had he use of for the use ulcer. heter for ed April haployee foley ng incont saturated blood				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395525		B. WING: _	00	04/25/2023	
IVY HILL REHABIL	VIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC IE NUMBER: 591902	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 6			F 0690			
SS=G							
	A review of Resident F	R1's hospice docume	entation				
	revealed that the reside		•				
	services on November	•					
	of R1's hospice record 8, 2023, stating that the		•				
	with the bleeding from	ū	Condition				
	Review of Resident R1	l's nursing note date	d April 9,				
	2023, at 3:29 a.m. by I	Licensed nurse, Emp	loyee				
	E11,	• ,					
	revealed that the hospic resident, and during the						
	with several extra-large	•	•				
	(larger then previously	-					
	which was also saturate	ed with blood, and the	he foley				
	catheter was also drain	ing bright red blood	. The				
	resident appeared to be	, ,					
	than usual, as the resid	•					
	care. The hospice nurse have another nurse out						
	nave anomer nurse out	in morning to rollov	w-up.				
	Review of nursing note	e date April 10, 2023	3, at 3:10				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395525		B. WING:		04/25/2023	
` '			L ROAD R, PA 19150		CTION (EACH	(X5)	
PREFIX TAG			R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE		COMPLETE DATE
F 0690 SS=G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION) Continued from page 7 p.m. by Licensed nurse, Employee E9, reve hospice had made a recommendation for ob UA C&S (urine analysis with culture and se test used in diagnosing urinary tract infection especially in patients who have a catheter infor an extended period of time) to rule out a (urinary tract infection) related to a change condition and hematuria (blood in the urine "MD's (physician) office and daughter were aware. Nursing to monitor." Continued review of nursing documentation April 10, 2023, at 9:18 p.m. by Licensed nu Employee E12, noted that urine specimen we obtained and placed in the refrigerator for the C&S test to diagnose a UTI. Further review of Resident R1's clinical receives a continued receives and the refrigerator of the C&S test to diagnose a UTI.		ensitivity ons, nserted a UTI in e). The e made n dated urse, was the UA	F 0690			
	red blood and blood cle incontinent brief.	ots in the resident's					

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(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
395525				04/25/2023	
	1401 IVY HIL	L ROAD			
,		ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
desident R1's daughtion with concerns hematuria and incomplete and properties of the placed to MD offin by hospice for a Use from office." 12, 2023, at 5:40 per soffice contacted the placed that R that the resident be increased secretion desident R1's daught ple party, at the face p.m. revealed that it hat it took the facility and increased secretion increased that it took the facility and increased the facility and increas	3, at inter was about reased fice to UA p.m. he facility in dated resident as sent out ins and iter, who ility on the lity too	F 0690			
da la	perficiencies (Each Deep y Full Regulatory of Ginformation) atted April 12, 202 esident R1's daught ion with concerns nematuria and inceplaced to MD off by hospice for a United to MD office." 12, 2023, at 5:40 poffice contacted to A C&S collection in the resident being documentation in the resident being decimentation in the resident R1's daught decimentation in the resident R1's	STREET ADDRESS, 1401 IVY HILL WYNDMOOR DEFICIENCIES (EACH DEFICIENCY Y FULL REGULATORY OR LSC INFORMATION) atted April 12, 2023, at esident R1's daughter was ion with concerns about nematuria and increased placed to MD office to by hospice for a UA	A. BLDG: B. WING: STREET ADDRESS, CITY, STATE, Z 1401 IVY HILL ROAD WYNDMOOR, PA 19150 DEFICIENCIES (EACH DEFICIENCY Y FULL REGULATORY OR LSC IG INFORMATION) F 0690 Atted April 12, 2023, at esident R1's daughter was ion with concerns about nematuria and increased placed to MD office to by hospice for a UA from office." 12, 2023, at 5:40 p.m. office contacted the facility A C&S collection. A C&S collection. Ing documentation dated in., revealed that Resident hat the resident be sent out increased secretions and A BLDG: B. WING: DEFICIENCES, CITY, STATE, Z 1401 IVY HILL ROAD WYNDMOOR, PA 19150 F 0690	STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD WYNDMOOR, PA 19150 DEFICIENCIES (EACH DEFICIENCY YPULL REGULATORY OR LSC GINFORMATION) F 0690 Atted April 12, 2023, at esident R1's daughter was ion with concerns about nematuria and increased placed to MD office to by hospice for a UA from office." 12, 2023, at 5:40 p.m. office contacted the facility A C&S collection. Ing documentation dated n., revealed that Resident that the resident be sent out increased secretions and Sident R1's daughter, who le party, at the facility on .m. revealed that the at it took the facility too	STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD WYNDMOOR, PA 19150

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	ON NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING: _		04/25/2023		
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902		&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD		•		
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES (EACH DI X MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0690	Continued from page 9			F 0690				
SS=G	which she, and everyor was causing her mother catheter, and her lethar visits which was not he pointed out the purple catheter bag every time mother's condition had when she first was awa 2023, until she demand hospital on April 13, 20 have any lab results an mother's UTI. Resider and said that her mother of two units of blood of Review of Resident R1 April 21, 2023, revealed completed 4/13/23 which urine color was red and Continue review of hospital complete blood of Hemoglobin level of 5 (dl) normal 12g/dl-16g	r's bleeding in her Fergy and sleeping throer norm. She stated are urine in her mother she visited and how continued to decline are of the bleeding or led that she be sent of 023, because the still divere not treating hat R1's daughter was er had to receive a trance she got to the horizontal records declaration are of bleeding or led a urinally sis laboration indicated that the dispital records revealed count) which revealed 2 grams (gm)/per decreeding through the count of the coun	oley bugh her that she her's v her the from h April 8, but to the l did not her upset ansfusion ospital. ated atory test the resident bood. ted a					

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* * * * * * * * * * * * * * * * * * * *		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
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NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D			STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD R, PA 19150			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OI FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0690	Continued from page 10			F 0690			
SS=G	the iron panel revealed consistent with iron de bleeding. Resident R1's blood transfusion, and red blood cells are a typroduct used for blood transfusion is typically patient has either lost a anemia that is causing transfused. Interview with License Manager on April 25, 2 that the facility became April 8, 2023, which sl Saturday. Hospice recowas on April 10, 2023, a sample that day. That results and when the day 2023, asking about the who said that they never Licensed nurse, Employer	results which were ficient anemia, likely s daughter consented that 2 units PRBC (ppe of blood replacent transfusions. PRBC given in situations was large amount of blood notable symptoms) where a ware of the bleeding and that the facility to it can take a day or aughter visited on Apresults she called the received the samp	y from I for backed nent where the bod or has were E9, Unit vealed ng on JA C&S collected two for pril 12, at lab le.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER				IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY	
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(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDI	ED BY FULL REGULATORY O FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
F 0690	Continued from page 11			F 0690			
SS=G	collect another urine sample to send out for C&S. That a sample was collected on April 2023, but that it had not been picked up by yet when the daughter arrived on April 13, demanding that her mother be sent out to the hospital. Interview with the Director of Nursing (DC April 25, 2023, at 2:15 p.m. confirmed that Resident R1's change in condition related to bleeding in her catheter and blood clots in 1 started on April 8, 2023, and that a urine sa was collected on April 10, 2023, at 10:30 p that it was picked up the next morning (April 2023) and that when the Licensed nurse, Er E9 called on April 12, 2023, she was told the was not received by the lab, and that another		the lab 2023, he ON) on t o her brief ample o.m. and oril 11, mployee hat it er order				
	daughter insisted her m confirmed that the char Saturday, April 8, 2023 sent out to the hospital April 13, 2023, and that	s noted on R1 was ursday,					
	was not received by the was initiated but it was daughter insisted her n confirmed that the char Saturday, April 8, 2023 sent out to the hospital	e lab, and that anoth s not processed before nother be sent out. The nge in condition was 3, and that Resident six days later on Th	er order re the The DON s noted on R1 was aursday,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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IVY HILL REHABILI	VIDER OR SUPPLIER: POST ACUTE NURSING OF TATION LLC	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOR	L ROAD				
STATE LICENSE NUMBER: 591902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOREST TO THE ACTION THE ACTION THE ACTION TO TH	OULD BE	(X5) COMPLETE DATE		
F 0690	Continued from page 12			F 0690				
SS=G	C&S results or treatmetime. The facility failed to enwas completed timely catheter who experience and presented with bloom actual harm to Reside the hospital, diagnosed and anemia and required. 28 Pa. Code:201.18(a)(228 Pa. Code:211.119c) 28 Pa. Code:211.119c)	nsure that laboratory for a Resident R1 with a urinary tract ed two units of PRBG (b)(1)(3) Manageme	testing ith urinary catheter e resulted insfer to infection C.					

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PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395525			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2023	
IVY HILL REHABIL	NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902			CITY, STATE, Z L ROAD 2, PA 19150				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0770 SS=D				F 0770				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395525		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2023	
IVY HILL REHABIL	VIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC SE NUMBER: 591902	&	STREET ADDRESS. 1401 IVY HIL WYNDMOON	L ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	THE VIBERT PERIOD CORRECTION (E.		(X5) COMPLETE DATE
F 0770 SS=D	Continued from page 14 483.50(a)(1)(i) Laboratory Serv §483.50(a) Laboratory Serv §483.50(a)(1) The facility n services to meet the needs o responsible for the quality a (i) If the facility provides its services must meet the applilaboratories specified in par This REQUIREMENT is not	ices. nust provide or obtain la f its residents. The facil nd timeliness of the serv s own laboratory service icable requirements for t 493 of this chapter.	ity is vices.	F 0770	Preparation & execution of the preparation of this plan of condoes not constitute admission agreement of the facts allege conclusion set forth in this statement of deficiencies. The of correction is prepared and executed solely because it is required by both federal and Element 1 -Corrective action R1 labs obtained by hospital labs obtained timely by facil reported to physician without recommendations. Element 2 Identification of a Residents All residents with physicians for laboratory services have potential to be affected Element 3 Systemic Changes Unit/Designee will review on listing report x last 2 weeks to facility obtained lab services timely manner	orrection n or ed or ne plan l/or state. n and R3 ity and it further at Risk s order the s rder to ensure s in a	Completion Date: 05/16/2023 Status: APPROVED Date: 05/12/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING:	<u></u>	04/25/2023	
IVY HILL REHABILI	VIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOR	L ROAD			
STATE LICENSE NUMBER: 591902 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) BUSINESS OF THE PROPERTY OF THE PROPERT				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0770	Continued from page 15			F 0770			
SS=D					Staff Development/Designee in-service licensed nurses on lab process. Unit Manager/D will review order listing reporting and audit we monthly x2. Audit findings we reported to QAPI monthly x2.	facility Designee Out in eekly x4, will be	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING: _		04/25/2023	
IVY HILL REHABILI	VIDER OR SUPPLIER: POST ACUTE NURSING OF TATION LLC E NUMBER: 591902	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOR	L ROAD			
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) EFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0770 SS=D	Continued from page 16 Based on review of clinical record and interviews with staff, it was determined that the facility failed to timely obtain laboratory services for two of three residents reviewed. (Resident R1 & R3) Findings include: Review of Resident R1's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 6, 2023, revealed that the resident was admitted to the facility, November 12, 2022, with diagnoses including, but not limited to middle cerebral artery stroke (MCA)		F 0770				
	weakness, sensory defi opposite side of the boo (UTI is an infection in including the kidneys, A review of the Reside revealed a nursing note Licensed nurse, Emplo received Resident R1 in	dy) and urinary tract any part of the urina ureters, bladder and nt R1's clinical reco es dated April 8, 202 yee E11, who noted	infection ary system urethra). rd 3, by that she				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395525		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2023	
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902			STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0770 SS=D	draining bright red block care the resident's income with bright red blood a clots with the largest the Further review of Residence and April 9, 20 by Licensed nurse, Employed that the hospice nurse with the exam the research arge bright red be previously) inside her with the saturated with blood, a also draining bright red to be very lethargic, even was falling asleep during indicated that she would morning to follow-up. Review of a verbal state of Nursing on April 25 E13, attending physicial that he had been contact.	dent R1's clinical red are size of a quarter. dent R1's clinical red 23 note written at 3: ployee E11, which it was in to assess resident presented with allood clots (larger that diaper, which was all not the foley catheter all blood. The resident en more than usual, and care. The hospice dent have another nurse dement taken by the 14, 2023, from the Eman, at 2:30 p.m. reve	enturated blood cord 29 a.m. endicated dent and en several an so was a appears as she en urse e out in director ployee aled that	F 0770			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING:		04/25/2023	
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC STATE LICENSE NUMBER: 591902		&	STREET ADDRESS, 1401 IVY HIL WYNDMOOR	L ROAD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)		ED BY FULL REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0770 SS=D	regarding a change in chematuria (blood in the and that he gave an ord (urinalysis) C&S (urin sensitivity test used in infections, especially in inserted for an extende who have painful urinathe specific germs causdetermine the most effective treatment). Review of nursing note Licensed nurse, Emplohad made a recomment to rule out a UTI (urina a change in condition a urine). Review of nursing note to rule out a UTI (urina a change in condition a urine).	de urine) in her foley of the to collect urine for the analysis with cultured analysis with cultured analysis with cultured analysis with cultured analysis who have deperiod of time and attion, and is used to the sing the infection and the ective medication to be dated April 10, 202 and analysis ary track infection) rund hematuria (blood on the April 10, 2023, roll and placed in the	catheter, or a UA ure and ract a catheter those find out d to use for 23, at hospice UA C&S elated to d in the	F 0770			

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE					(X3) DATE SURVI COMPLETED:	(X3) DATE SURVEY COMPLETED:			
				A. BLDG: _ B. WING: _	00	04/25/2023			
		395525		D. WEIGE_		04/23/2023			
	VIDER OR SUPPLIER: POST ACUTE NURSING	ρ.	STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD						
	TATION LLC	œ.	WYNDMOOR, PA 19150						
	501003								
STATE LICENS (X4) ID	E NUMBER: 591902 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)		
PREFIX	MUST BE PRECEEDE	ED BY FULL REGULATORY O		PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	COMPLETE		
TAG	IDENTII	FYING INFORMATION)			CROSS-REFERENCED TO THE .	APPROPRIATE	DATE		
F 0770	Continued from page 19			F 0770					
SS=D									
55 D	Review of an April 12,	, 2023, at 1:54 p.m. i	evealed						
	that Resident R1's daug	•							
	nurse's station with cor	ncerns about her mot	ther						
	related to her hematuria	a and increased tracl	1						
	secretions. A call was p	placed to the physici	an's						
	office to approve a reco	ommendation by hos	spice for						
	a UA C&S and that she	-							
	from the physician's of								
	nursing notes revealed	-							
	5:40 p.m. revealed that								
	contacted by physician								
	entered a verbal order	for a UA C&S collec	ction.						
	Review of an April 13,	2023 nurse reveale	d that						
	Resident R1's daughter								
	be sent out to hospital	-							
	increased secretions an								
	An interview with the Resident R1's daughter		ter, who						
	is the resident's responsible party, at the facility		cility on						
	April 25, 2023, at 12:5	0 p.m. revealed that	the						
	daughter was frustrated	d that it took the faci	lity too						
	long to diagnose and tr	reat her mother for a	UTI						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING:		04/25/2023	
IVY HILL REHABIL	VIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC IE NUMBER: 591902	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0770	Continued from page 20			F 0770			
SS=D	which she, and everyor was causing her mothe catheter, and her lethar visits which was not he pointed out the purple catheter bag every time urine to be tested since bleeding on April 8, 20 she be sent out to the hecause the still did no were not treating her mandaughter was upset and receive a transfusion of got to the hospital. A review of Resident F April 21, 2023, revealed panel with results which deficient anemia, likely daughter consented for units PRBC (packed reblood replacement professions. PRBC transfusions. PRBC transfusions. PRBC transfusions. PRBC transfusions.	er's bleeding in her forgy and sleeping throe er norm. She stated are urine in her mother she visited and asked she became aware of 223, until she demandospital on April 13, at have any lab result nother's UTI. Resided said that her mother are units of blood extra hospital records and lab tests, including the were consistent why from bleeding. Residual blood cells are a tyduct used for blood	oley ough her that she her's ed for the of the ded that 2023, s and ent R1's er had to once she dated g iron ith iron sident R1's and 2 ype of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395525		B. WING: _		04/25/2023	
IVY HILL REHABIL	OVIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC SE NUMBER: 591902	&	STREET ADDRESS, 1401 IVY HILL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	· ·			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0770	Continued from page 21			F 0770			
SS=D	situations where the paramount of blood or has notable symptoms) we Interview with License April 25, 2023, at 1:20 facility became aware 2023, which she pointers aid that hospice recommon was on April 10, 2023, a sample that day. She two for results and whe April 12, 2023, asking that lab who said that the sample. The UM said the collect another urine sate C&S. She said that a sate, 2023, but that it hall ab yet when the daugh 2023, demanding that thospital.	ed nurse, Employee I p.m. revealed that to of the bleeding on A ed out was a Saturda numendation for a UA, and that the facility said that it can take en the daughter visit about the results she hey never received to that she then got an orample to send out for ample was collected d not been picked up ther showed up on A ther mother be sent or	E9, on he pril 8, y. She A C&S collected a day or ed on e called he order to r a UA on April b by the pril 13, ut to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:			
		305525			00	04/25/2023			
		395525							
	VIDER OR SUPPLIER: POST ACUTE NURSING	&	STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD						
REHABIL	ITATION LLC		WYNDMOOF	R, PA 19150)				
STATE LICENS	e number: 591902								
(X4) ID				ID	PROVIDER'S PLAN OF CORRE	· ·	(X5)		
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SE CROSS-REFERENCED TO THE		COMPLETE DATE		
F 0770	Continued from page 22			F 0770					
SS=D									
	April 25, 2023, at 2:15	p.m. confirmed that	Ī						
	Resident R1's change i								
	bleeding in her cathete								
	started on April 8, 202		-						
	was collected on April	, , ,							
	that it was picked up the 2023) and that when L								
	called on April 12, 202	•	-						
	not received by the lab								
	initiated but it was not								
	daughter insisted her m	-							
	confirmed that the char								
	Saturday, April 8, 2023	-							
	sent out to the hospital	six days later on Th	ursday,						
	April 13, 2023.								
	Review of Resident R3	B's Quarterly MDS d	ated						
	April 5, 2023, revealed	· •							
	admitted to the facility	, October 9, 2022, w	ith						
	diagnoses including, bu	ut not limited kidney	transplant						
	and an elevated white b	blood cell count.							
	A review of an April 1	8, 2023, progress no	te						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395525		A. BLDG:00 B. WING: 04/25/2023			
IVY HILL REHABIL	VIDER OR SUPPLIER: POST ACUTE NURSING ITATION LLC SE NUMBER: 591902	&	STREET ADDRESS, 1401 IVY HIL WYNDMOOF	L ROAD			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0770	Continued from page 23	ontinued from page 23		F 0770			
SS=D	written at 11:27 a.m. reneed bloodwork and a appointment with kidn put in lab book and Lie aware. A review of facility lab revealed urinalysis col at 7:00 a.m. and a first 2023. Interview with the Dire April 25, 2023, at 2:15 Resident R3's labs, incordered on April 18, 20 picked up till April 20, were not available until days later.	urine analysis for he ey transplant progracensed nurse was made report for Resident lection date of April report date of April report date of April luding urinalysis, wo 023, and the sample 2023, and that the rel April 21, 2023, over	er m, labs ade R3 20, 2023, 21, ON) on t ere was not results er three				
	28 Pa. Code 211.12(d	-					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 395525			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2023		
NAME OF PROVIDER OR SUPPLIER: IVY HILL POST ACUTE NURSING & REHABILITATION LLC			STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 IVY HILL ROAD WYNDMOOR, PA 19150				
STATE LICENSE NUMBER: 591902			WYNDMOOR	K, PA 19150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0770	Continued from page 24			F 0770			
SS=D	services						

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Certified End Page

IVY HILL POST ACUTE NURSING & REHABILITATION LLC

STATE LICENSE NUMBER: 591902 SURVEY EXIT DATE: 04/25/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY